Report

Of the

Findings and Recommendations

Of the

Adult Care Home Cost Modeling Committee

Mission:
To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met.

December 17, 2004
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***Revisions were due to modifications to cost information presented in Attachment 6, references quoting information from Attachment 6 and other minor edits.**

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List of Acronyms

ACH – Adult Care Home
ADL – Activities of Daily Living
APA – Administrative Procedures Act
CFR – Code of Federal Regulations
CMS – Centers for Medicare and Medicaid Services
COLA – Cost of Living Adjustment
CPI – Consumer Price Index
DFS – Division of Facility Services
DHHS – Department of Health and Human Services
DAAS – Division of Aging and Adult Services
DOL – U.S. Department of Labor
DSS – Division of Social Services
EIS – Eligibility Information System
FCH – Family Care Home
FL-2 – Level of Care Designation Form
FRV – Fair Rental Value
FTE – Full Time Equivalent Staff
HAL – Homes for the Aged
HML – Homes for the Mentally Ill
IPD – Implicit Price Deflator
MDS – Minimum Data Set
MMIS – Medicaid Management Information System
NF – Nursing Facility
OSBM – North Carolina Office of State Budget and Management
PCS – Personnel Care Service
RN – Registered Nurse
RUG – Resource Utilization Grouper
SA – State and County Special Assistance
SCU – Special Care Unit
SMM – State Medicaid Manual
SSA – Social Security Administration
SSI – Supplemental Security Income

Executive Summary

In October 2002, DHHS Deputy Secretary Lanier Cansler announced the formation of an Adult Care Home Cost Modeling Committee (hereinafter referred to as the Committee) to study "the development of a consistent costing methodology" to establish rates for State and County Special Assistance (SA) and Medicaid Personal Care Services (PCS) which fund the care of approximately 70% of the residents in North Carolina's Adult Care Homes (ACHs). (See Attachment 1 announcing formation of the Committee and Attachment 2 for a list of Members of the Committee.) At that meeting, the Deputy Secretary explained that he and the Secretary frequently heard complaints from providers about staffing needs beyond their ability to pay and beyond regulatory requirements, that reimbursement was insufficient to maintain a reliable workforce to meet resident care needs, and about unfairness in determining the capital cost component of the rate. They also heard complaints from advocates and the general public about failure to properly care for residents. Deputy Secretary Cansler's intent in forming the Committee was to develop an improved methodology for establishing an accurate and fair reimbursement rate that is based upon the substantiated care needs of the existing residents and a standardized quality of care.

The Committee agreed to the following mission: **To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met.** The Committee did not start with any preconceived target rate; rather, it started with gathering appropriate cost information from the provider community and identifying demographic and medical care needs of the population served. Excellent discussion occurred on the array of issues surrounding the continuum of care for North Carolina residents in these facilities: appropriate staffing to meet resident care needs, staffing required by licensure, determining resident mix and how that impacts cost of care, processes used to track and report costs, the cost of meeting regulatory requirements, appropriate reimbursement for the capital cost component of facilities, and whether North Carolina's Medicaid State Plan provides the flexibility of process and definitions utilized by other states, among other issues. From these discussions a matrix of both long term and short term actions was developed. (See Attachment 3 for the final version.)

In North Carolina, Homes for the Aged Licensed (HALs) are licensed as either ACHs and have 7 or more beds or as Family Care Homes (FCHs) and are licensed for 2 to 6 beds. In response to a growing number of facilities advertising special care for persons with Alzheimer's Disease or other related forms of dementia, the State established an "Alzheimer's Special Care Unit" (SCU) designation which applies to either stand alone facilities or separate units within the ACH spectrum. For purposes of this study, the Committee focused only on HALs of thirty or more beds, with and without SCUs and those that were SCU only. (Note: Due to the limited number of facilities with SCU beds, some facilities had as few as 24 beds.)

The methodology utilized by the Committee consisted of deciding upon the model approach and developing the model, gathering and analyzing cost/rate information, creating a new method for determining capital costs, assessing resident care needs, and extensive research of Federal and other state approaches to providing care to this population. All this was done under one condition--that no one currently receiving State and County Special Assistance (SA) would be disenfranchised from appropriate SA and Medicaid coverage as a result of our recommendations. Over the long term, this methodology allows for future rate setting that can be updated for

inflation, for changes in facility and care standards and periodically adjusted to reflect resident populations and staffing requirements. The ultimate goal of such a process is to develop an operational environment that produces higher standards of care for ACH residents.

Adopting the cost model approach recommended by the ACH Cost Model Committee will result in allocating more hours to appropriately address client care needs and increasing salaries and benefits to ensure a stable and competent workforce. The Committee discovered that while NC had based its PCS reimbursement on 1.1 hours per resident per day, in fact**,** resident assessments, when compared to national studies, indicate a need for 2.31 hours for basic ACH residents and 4.07 hours for SCU residents. Additionally, North Carolina salaries and benefits are currently below national averages. Most alarming is that many fragile older residents are being housed with younger and stronger, often mentally ill, residents. Making these changes will change the current daily rate for basic PCS in HALs and in SCUs, which is $18.57 (based on the current 1.1 hours per resident per day) to $41.26 for residents in HALs (based on the recommended 2.31 hours per resident per day) and $72.69 for residents in SCUs (based on the recommended 4.07 hours per resident per day). (Note: $18.57 is actually the weighted average for the 1-30 bed category and the 31+ bed category.)

North Carolina's system of long term care has consistently been noted to be a fragmented "patchwork" of programs and very confusing to consumers seeking long term assistance and support. The 2001 NC Institute of Medicine's Task Force on Long Term Care made a number of recommendations involving the creation of a uniform system of entry into long term care. The Division of Aging and Adult Services (DAAS) has received a Federal grant to work on a pilot project to design and implement a community-based information and assistance program for the elderly and the disabled. DAAS has looked to DMA to ensure that a pilot, chronic care management component is developed as part of the overall design.

Should the State decide to (1) increase the public financing for ACH services to more accurately reflect the cost of care; (2) create different rates to acknowledge the higher cost of care and staffing needs of SCUs; and (3) make sure that persons with mental health needs get the appropriate treatment services upon admission and following placement, then there needs to be good screening, assessment and client tracking systems developed for ACHs. These management systems would include the following:

1. An improved pre-admission approval system with mental health screening;
2. A prior approval system for SCUs;
3. Medicaid criteria for placement purposes;
4. Use of more sophisticated and automated assessment and care planning tools to help facility staff manage their residents; and
5. Utilization management and quality assurance programs to assist the State in monitoring care, services and placement.

Numerous recommendations have been identified as a result of the Committee's work. Legislation, IT systems, rules and processes must be adjusted or developed. Implementation will not be easy or inexpensive, but the methodology provides a firm foundation for future rate setting. As stated above, based on resident care needs identified through the resident assessments conducted, staffing levels must be increased. The Medicaid PCS cost of implementation will be $188,854,207 ($120,167,932, Federal; $50,152,255, State; and $18,534,020, county). The detail breakout to implement the 2.31 and 4.07 PCS hours per day for all HAL and SCU Medicaid ACH-PCS is:

- ACH-PCS for HAL Facilities (2.31hr/day) equals $180,096,959
- ACH-PCS for SCU Facilities (4.07hr/day) equals $8,757,248

For SA there will be an additional $9,980,260, evenly split between State and county funds, to raise the existing rate to $1124. There will be cost associated with the proposed adoption of an income disregard payment to avoid disenfranchising current SA recipients in the amount of $22,660,113 ($14,411,910, Federal; $6,335,278, State; and $1,912,925, county). See Attachment 6 for a full breakout of these costs. As yet undetermined expenditures will also be required to implement systems changes for the income disregard. Additionally, the recommendations surrounding the screening and assessment processes to ensure residents are placed in the appropriate long-term care setting according to their care needs will cost an estimated $850,000 in developmental costs and $1,344,000 in annual operations. See Attachment 7 for a full breakout of the costs associated with screening and assessments.

Along with these recommendations for increased assessments, salaries and benefits for ACH workers, and increased hours of care for residents, the Committee recognized the need for verification that the increased rate is directed toward quality improvements in resident care. This will be closely watched through routine monitoring and random audits. Additionally, DHHS has included in its expansion budget request additional resources to expand expectations from county Adult Home Specialists for improved inspection and oversight. This is the first time in many years the Department has addressed cost reimbursement in such a thorough and systemic way. The Committee acknowledges that whatever the rate methodology or reimbursement amount, the General Assembly has the final decision on setting the rate. We believe adopting the suggested rate setting model will provide members of the General Assembly, the public, residents and providers, a clearer understanding of the costs of care and a balanced mechanism for determining rates. Very likely the General Assembly will find this package difficult to finance immediately, however, recommendations are closely linked and must have coordinated implementation to succeed.

Subsequent to the completion of the draft report, it was reviewed by representatives of the North Carolina County Commissioners Association and the North Carolina Association of Directors of Social Services. Both organizations agreed with the focus on resident care and, in general, support the recommendations of the report. Indeed one reviewer commented, “The challenge from our perspective seems to be making sure that additional funding is channeled into direct care and services for residents. This study seems to be a first step in that direction.” As expected, there is concern over the increased funding required at the county level.

Representatives from several advocacy groups also reviewed the draft report and support the cost model approach as a systemic way to determine rates based on resident care. All reviewers recognize, as does the Department, that there will be challenges in implementing the recommendations. Some of these challenges are appropriate training for providers on the assessment process, determining the best entity to perform such assessments, development of performance expectations and frequency of application of the inflation factor. These and other implementation details will be resolved by a representative group of individuals at the time the approach is approved.

Developing the Model

Because of the desire of the ACH Cost Modeling Committee to develop a rate that provides more standardized quality to these facilities, it was agreed to develop the cost model from data gathered from selected cost effective and efficiently run facilities which met established criteria determined by the Committee rather than on the basis of all facilities. Since industry representatives frequently commented that the cost report format did not properly reflect the true cost of meeting the care needs of residents as opposed to the regulatory requirements, the format was modified to allow providers to justify increases for staff, benefits or other support line items necessary to meet both regulatory requirements and the care needs of residents with the intent that this would provide valuable comparative staffing and cost data later. A separate subcommittee was established to address the perceived inequities of the capital cost component of the cost reports.

Letters were sent to identified facilities explaining the cost model concept and asking for participation. Training was provided to the selected model facilities in three locations around the state (Hickory, Raleigh and Greenville) to explain the revised cost report format and how it would be used and to answer questions about terminology and definitions. Although the training was provided in April 2003, the Committee was still waiting for some revised cost reports from selected facilities in January 2004. Once the completed, revised reports were received, the staff of the DHHS Controller's Office clarified information to ensure completeness.

During the development of the modeling process and selection of facilities to use in the model, extensive research was conducted of Medicaid State Plans in other states, different methods of costing the capital component and resident assessments were performed. These efforts are discussed in the following sections: Rate Setting and Fiscal Impact, the Capital Cost Component, Resident Assessments and Research.

Rate Setting & Fiscal Impact

Selection of Facilities for the Model
The first step in developing the cost model consisted of identifying representative facilities to participate in the study. Two types of HAL licensed homes were originally targeted: (1) facilities that are entirely SCUs or that have SCUs, and (2) those without SCUs. With the assumption that different sized facilities would have diverse levels of staffing requirements as well as varying levels of costs, the modeled facilities were grouped according to the number of licensed beds. See Selected Information for HAL Model Facilities and Selected Information for SCU Model Facilities at Attachments 4-1 and 4-2, respectively.

The following criteria were applied to select facilities for the modeling process:

- Appropriate geographical and urban rural representation
- Mixture of both private pay and public funding
- Occupancy rate at a minimum of 80%
- Include Special Care Units (SCUs) within facilities and those that are stand-alone facilities
- Representation from the following size categories: 31-60 beds , 61-90 beds, and 91+ beds
- Must have been in business for at least one year
- Minimum of 3 facilities per group (therefore 5 were identified to allow for refusals to participate or other probabilities of non-participation)
- No disproportionately high indirect cost ratios compared to direct costs
- No history of penalties and fines
- Those facilities that met the above criteria, were reviewed by industry representatives, the local Departments of Social Services, and the Friends of Residents in Long Term Care as efficient and respected facilities with a good reputation for serving residents

Analyzing the Cost Information
Once the cost reports were received from the model facilities, the painstaking process of analyzing the information started. The cost model began with the existing cost report of each facility and then incorporated the flexibility to address cost needs that are not adequately compensated in rates that are based solely on historical costs adjusted for inflation. One of several needs that industry representatives cited which impacts the care that residents receive is the inability of the facility to fund benefits for full time staff at the existing reimbursement rates. Lack of benefits creates employee turnover and negatively impacts the quality of care provided to the residents. Therefore, the facilities were given the opportunity to add costs for "additional needs" identified at their facility and explain how these additional needs were important for the care of their residents.

The format of the cost report classifies expenditures into specific categories: SA, PCS, Administrative, Medical Transportation, Mental Health Services and Non-Reimbursable Costs. Rates for SA and PCS are based upon the following cost components:

SA

- Housekeeping and Laundry
- Dietary
- Recreational Activities
- Property Ownership and Use
- Operations and Maintenance

PCS

- Personal Care Services
- Health Services
- Initial Orientation/Aide Training

Costs excluded from the analysis are Non-Reimbursable, Mental Health Services and Medical Transportation since these costs are not related to SA or PCS. Medical transportation is reimbursed by Medicaid in a separate process, and Administrative costs were allocated across all cost components above.

The 2002 cost report format and data formed the basis for the modeling exercises. Following are the assumptions and methodologies used in compiling the cost model:

- Assumed the costs in the 2002 cost reports reflected staffing in compliance with North Carolina licensing and operating requirements.
- Additional needs for providing adequate services to meet the unique care needs of the population were identified by the facilities and added to the 2002 base.
- Added costs for current full-time staff in cases where staff had been added subsequent to the submission of the cost report.
- Facilities were asked to separate hours reported on their original cost report into regular and overtime hours so that an appropriate adjustment could be made for the additional cost of overtime.
- PCS FTEs were calculated as follows:
  1. First Line Supervisors – staffing requirements per 10A NCAC 13F.0605
  2. Medication Aides – 37 minutes per resident per day. (Source: An analysis conducted by Jan Brickley, a DFS pharmacist, in 1999, to determine additional work effort required by medication administration rules made effective in 2000.)
  3. Resident Aides – Myers & Stauffer RUG analysis (described later in this report).
  4. Registered Nurses – 1.15 hours per resident per month needing RN services. (Source: Information provided by the NC Assisted Living Association based on Licensed Health Professional Support requirements for RN competency for certain tasks in 10A NCAC 13F.
  5. Median hourly wage rates established by the U.S. Department of Labor (USDOL) for North Carolina were used to calculate salaries by job classification for full-time FTEs. These wage rates were inflated annually based upon inflation factors provided by the N.C. Office of State Budget and Management (OSBM). Casual labor costs were also inflated by these percentages.
- Benefits were calculated on the 2003-04 average benefit rate of $2.44 per hour for each full-time position identified by the facility. Inflation factors provided by OSBM were applied annually. The benefit rate is based on the employer costs for

employee compensation for paid leave, insurance, retirement and savings. (Source: DOL, Bureau of Labor Statistics.)

- Payroll taxes were calculated on total salaries which are based on the inflated hourly wage and include additional FTEs identified by the facilities and Myers & Stauffer's staffing recommendations in the PCS cost center.
- Non-labor expenses were based on reporting year 2002, and have been inflated by applying the annual Gross National Product Price Deflator provided by OSBM.
- A capital cost adjustment of $11.16 was included in the SA rate and was calculated as an average of the 2002 and 2003 capital adjustments of $13.58 and $8.74 per month, respectively. No inflation factor was applied.
- Non labor costs were inflated to reflect projected costs for SFY 2005-06.

To arrive at the PCS FTEs described above, the committee reviewed Myers & Stauffer's analysis of the resident assessments to gain insight into the mix and to understand the resident care needs in ACHs. (See the following section on Resident Assessments.)

Establishing the Rates

Once all components of the cost report were analyzed and combined, the SA and PCS rates were reviewed. Although rates did vary between the different size categories of the non-SCU ACHs, setting separate rates by facility size is not allowable based on current APA rules and payment structures. As such, only one rate was determined for the non-SCU facilities.

The proposed SA rate for the non-SCU adult care homes based on the cost modeling exercise was calculated to be $1,124 per month for 2005-06 compared to the recently established rate of $1,084 per month (effective 10-1-04). The cost model for the SCUs yielded a rate of $1,515 per month versus the $1,084 SA rate in effect. SCUs typically have a lower number of SA residents, thus the financial impact is not excessive. The higher SCU rate was expected since the maintenance and level of care of the SCU residents are more extensive than the non-SCU residents. This finding was supported by information gathered on residents' needs using an assessment process that served as a key component to the ACH cost modeling and is described in more detail later in this report. (See Attachment 5-1 and 5-2 for Rate Proposal for Non-SCU Facilities and for Rate Proposal for All SCU Facilities, respectively.)

The SA rate under the cost model yields a forecasted increase of nearly $10M in SA payments in fiscal year 2005-06 from fiscal year 2004-05. This cost represents an increase in the SA payments to current SA recipients and an average increase of 19 new SA eligibles per month in non-SCU facilities. Only 5 new eligibles per month are projected for SCU facilities from among the currently eligible group. The PCS cost of implementation will be $188,854,207 ($120,167,932, Federal; $50,152,255, State; and $18,534,020, county).

Capital Cost Reporting

Capital costs are typically defined as depreciation, amortization, lease, and mortgage interest expenses, but may include other related expenses such as property taxes and property insurance. Capital costs can also include rent paid to another facility owner. Traditionally, North Carolina has reimbursed facilities using a single state-wide rate based on facility cost reports, as reported in various "cost centers". Historically the "capital cost center" did not recognize cost of capital, differences of ownership structure, whether facilities were owned or leased, geographic cost-of-living differences, and existing tax laws. The ACH Cost Modeling Committee recognized the need to address capital assets in a more thorough manner and formed a Capital Cost Modeling Subcommittee led by the DHHS Internal Auditor. The objectives of the Subcommittee were to develop a methodology based on the need to administer an equitable return on facility investment, minimize administrative costs associated with capital reimbursement, and to standardize the rate setting process so that it would be more easily understood and evenly applied.

The Subcommittee contacted Myers & Stauffer, LLC, to find out more about approaches used by other states. Fortuitously, in 1998, Myers & Stauffer, LLC, developed a report for the State of Washington comparing property payments for nursing facilities. Generally, states use one of four methodologies to reimburse capital costs: (1) flat rate, (2) cost based, (3) fair rental, or (4) blended. Each of these methodologies has unique advantages and disadvantages which are more fully described in Addendum 1, Adult Care Home, Capital Cost Reimbursement Study, Position Paper, dated May 2004. The Subcommittee weighed and considered each of the four alternative approaches in order to develop a recommendation for the full committee. Using the Myers & Stauffer, LLC, study and adapting the historical information contained within NC's cost reports, the Subcommittee recommended a fair rental value (FRV) approach to capital reimbursement. This approach treats capital components from a rental vantage point similar to renting other lodging, a hospital bed or office space. Under this concept, government is not interested and does not become involved in real property management issues/costs such as mortgage interest, capitalization policies (depreciation), leasing, repairs and renovations and a host of other ownership issues. The FRV concept merely looks at the value of the space from a rental perspective.

In essence, the variation of the FRV approach chosen utilizes the adjusted county tax appraisals for the various facilities and applies a rental factor. The Subcommittee selected 2001 as a hold harmless base year and then calculated the facility FRVs for the following two years and applied an Implicit Price Deflator IPD (which adjusts for inflation). For 2002, this process resulted in increased Special Assistance monthly costs/rates of $14 (from $1183 to $1197 per bed). For 2003, the Special Assistance monthly cost/rates would have increased by $9 (from $1,188 to $1,197 per bed). These resulting increases are currently small due to the low inflation rates which have been experienced over the last few years. As inflation increases, the limiting IPD factor would also increase, providing a greater increase in allowable costs.

Resident Assessments Process

The Need for Resident Assessments

Over the course of the last several years, the resident "mix" in ACHs has changed. Some of this change may be due, in part, to the US Supreme Court Olmstead ruling of 1999 and subsequent state planning efforts to divert or transition residents away from state psychiatric hospitals towards the least restrictive appropriate level of care, which has in turn increased the mentally ill population in ACHs. Younger persons with varying forms of mental illness are being placed in facilities with older, more physically frail populations. Increasing populations of residents with greater health care needs and with a diagnosis of mental illness have resulted in the promulgation of rules over the past several years addressing medication administration, staff training, resident assessments and care plans, and licensed health professional support. The mix of frail elderly with younger, mentally ill residents is of growing concern considering minimum staffing requirements and the lack of mental health resources in many areas of the State to provide needed services to mentally ill residents.

Other forces that may be impacting the overall composition of the population dependent on public funds and living in adult care homes include: (1) the increase in the availability of newer Assisted Living facilities which offer more options to the private pay resident and those elders able to make choices about living options, and (2) the SA In-Home Program, operated through local departments of social services, which allows persons who "qualify" for placement in an ACH to live in their private residences. The Committee felt that the combination of these and other factors had resulted in an ACH population with many chronic medical conditions, high levels of mental health needs, and heavy Activities of Daily Living (ADL) needs which together make the population much more dependent on personal care assistance. Yet, industry representatives informed the Committee that regulatory staffing requirements have not changed to reflect the care needs of the population. For these reasons, from early in the deliberations of the Committee, the need for a comprehensive assessment of the resident population was identified.

The current placement process for persons dependent on public funding entering ACHs and the ongoing assessment process of ACH residents are:

> *A person's attending physician must complete and sign a one-page FL-2 form that includes the current and recommended level of care, the diagnosis of the client and any other pertinent information about the client, including items such as functionality and medications. Within 72 hours of admission, the facility conducts an initial assessment of the resident using the Resident Register, an informational form required in rule as part of the admissions process. Another assessment is conducted within 30 days of admission and annually thereafter using the DMA 3050-R or an equivalent. In almost every case, all of the assessments tools are completed manually by the physician or the facility staff.*
> (NOTE: An electronic FL-2e is currently available through ProviderLink, Inc. and is being used primarily for prior approval of nursing facility admissions.)

None of the above mentioned forms are considered a comprehensive assessment instrument nor is the information on the ACH resident recorded in a format that would support data collection or a statewide comparative analysis among the ACH population and populations in other long-term care settings.

To assist in the resident assessments and analysis of the assessment data in a timely manner for the work of the Committee, the Division of Medical Assistance used an existing contract with the consulting firm of Myers & Stauffer, LLC. This firm is known for its expertise in the Minimum Data Set (MDS) assessment tool and the Resource Utilization Grouper (RUG) scoring system. The study was approached in two phases to provide the Committee with assurance that the data collected would produce the outcomes necessary for good decision making. One of the major components of the work performed by Myers & Stauffer, LLC, was a statistical comparison of the ACHs using the same methodology as other national studies to determine staffing needs.

The Assessment Process

The MDS is a **well-researched resident assessment instrument** used nationally by all Medicare certified nursing facilities, and this instrument was determined by the Committee to be the best option available for gathering information on the care needs of the ACH residents. Closely associated with the MDS is the Resource Utilization Grouper (RUG) resident classification system. The RUG system uses information from the MDS to categorize residents into one of 34 different groups based on the intensity of medical conditions/needs, including cognitive impairments and functional limitations as measured by the ability to perform ADLs. ADL needs are a critical component to calculating overall resident needs and are important in determining the outcome of the RUG analysis and staffing requirements. The RUG analysis was performed using the same methodology used in a nursing facility time study conducted from 1995-97 by CMS, and this analysis informed the Committee of the quantity and levels of staffing time required to meet the unique care needs of the residents. (NOTE: A modified MDS 2.0 version was completed by contract nurses during the assessment process. The RUG analysis was performed using RUG-III 34 classification system, Version 5.12.) Once the decisions were made on the assessment instrument and the methodology for analysis of the data, the next step was to determine who would perform the assessments. The Division of Medical Assistance entered into a contract with the Association of Home and Hospice Care of NC for the services of nurse assessors located throughout the State. These nurse assessors were employees of local home health agencies. The contract nurses went on-site to the ACHs selected for the study and completed the MDS on all the residents in the facility (Medicaid and private pay). Although the contract nurses were required to be proficient with the MDS, Myers & Stauffer, LLC, provided "refresher" training via teleconferencing.

All of the facilities participating in the cost modeling received materials in advance to explain the purpose of the study and to provide names of contact persons should there be questions. In addition, the facilities were provided with a copy of the MDS guidelines. The nurse assessors used observation, medical or other resident charts, talked with the facility staff and gathered resident input to complete the MDS. Once the nurse assessors completed the MDS assessments on the residents in the selected facilities, the forms were mailed to Myers & Stauffer, LLC, for data entry and RUG analysis. The analysis would produce a comparison of resident profiles between ACH and nursing facilities on available data elements, including:

- RUG distribution (by group and score)
- Cognitive Performance Scale scores
- ADL scores
- Payer source breakdown
- Selected conditions or "outliers"
- Demographics of population

In order to accommodate review and decision making by the ACH Cost Modeling Committee, the assessments were performed in two phases, the first for non-SCU facilities and the second for SCU facilities and MHLs. Actual on-site visits by the contract nurse assessors started June 20, 2003.

Phase I:

- August 2003 – Myers & Stauffer, LLC, completed an analysis on four ACH facilities which included 215 assessments. After review of the analysis, the Committee decided to add a fifth facility to address the concern that the first four facilities did not adequately reflect a population with mental health needs. In December 2003, the fifth facility analysis was completed, increasing the total number of assessments to 270.
- December 2003 – Assessments were completed on a total of 549 ACH residents in nine facilities, bringing the total number of assessments to 819.
- January 2004 – A report was submitted by Myers & Stauffer, LLC, for review by the ACH Cost Modeling Committee.

Phase II:

May 10, 2004 – Myers & Stauffer, LLC, completed the final report adding the Phase II resident assessments that included 11 ACH special care units (SCU) and 8 mental health group home facilities to the Phase I resident assessments. The total assessments for ACH residents now reached 1,137 and 28 mental health residents.

Myers & Stauffer, LLC, issued a final detailed report to the Committee on May 10, 2004. The complete, final report, which provides details on the findings of the MDS results and the RUG analyses, is attached to this report.

Highlights of the MDS Resident Assessment Report

The Adult Care Home population looks similar to the nursing facility population in most of the MDS categories. The SCU population that represents residents with Alzheimer's or related dementia demonstrates more memory issues and a higher level of behavior problems, requiring cueing and supervision. Overall, in the ADLs, the nursing facility population was far more dependent than any of the ACH population. However, the ACH SCU population reported a heightened need for assistance in dressing, toilet use, personal hygiene and bathing--all ADL needs.

The RUG scores reflected the wide range of residents needs. Most of the residents (51%) clustered at the lowest RUG category, Reduced Physical Functioning. The overall results in RUG scores for the 1,137 residents were:

- Reduced Physical Function 582 residents (51%)
- Impaired Cognition 397 residents (35%)
- Clinically Complex 110 residents (9.6%)
- Behavior Problems 32 residents (2.8%)
- Special Care 10 residents (<1%)
- Extensive Services 5 residents (<1%)
- Special Rehabilitation 1 resident (<1%)

For the Mental Health Group Homes, of the 28 residents assessed:

- Impaired Cognition 16 residents (64%)

- Special Care 5 residents (20%)
- Special Rehabilitation 1 resident (4%)
- Reduced Physical Function 6 residents (12%)

Improved Screening and Resident Assessment Program Needed

As noted above, entry to an ACH is based on the recommendation of a physician and the physician's signature on a completed, one-page, FL-2 form that documents the overall health care needs/medical conditions and ADL needs of the individual. Once a physician signs the FL-2, the form is sent to the local DSS for determination of placement and eligibility for SA and Medicaid. Although Medicaid heavily funds care needs of residents in ACHs, it does not control the admission process, and there is no Medicaid admissions criteria with which to inform physicians regarding level of care and personal care needs. In addition, there is no formal screening to identify persons with mental health needs or whether they are receiving mental health treatment. Since concerns with quality of care often focus on the issue of mental health services to ACH residents, it is critical that the State make sure that persons with mental health needs are identified and followed by the appropriate health care professionals. (NOTE: The MDS resident assessments performed as part of this study reflect similar data gleaned from a recent Mental Health Screening Project conducted by First Health, Inc. for DHHS. This project clearly shows a high level of ACH residents with behavior and mental health problems. The Mental Health Screening Project indicated that over 40% of the ACH residents included in the sample had mental health problems that required some level of intervention and treatment services.)

Adult care homes serve as a major component of North Carolina's long-term care delivery system, and it is time for the State to move aggressively to implement improved management tools and systems to respond to the growing needs of the adult care home population and to bring more accountability to the program. See Attachment 7 for a list of program enhancements and estimated costs.

Research

Background
The public funding for ACH residents comes primarily from two sources. The first source is from the State and County Special Assistance Program (SA) which is 50% State funds and 50% County funds and is the payment for room and board. The second source of funding is Medicaid. In 1995, Medicaid funds began reimbursing the ACHs for Personal Care Services (PCS). Personal Care Services include "enhanced" personal care services, which provide an additional payment to the ACH. Enhanced PCS must be prior approved by a local agency case manager using Medicaid criteria for residents needing more extensive care. Early discussions in the Committee focused on the Medicaid definitions of PCS, Enhanced PCS, and how PCS provided in the community differ from PCS provided in the ACH setting. Research indicated that expenses covered under the SA rate for room and board in North Carolina were not comparable with what is covered in other states. This led early in the life of the Committee to shifting Initial Orientation/Aide Training and Health Services from the SA rate to the PCS rate. While this shift more appropriately allowed for an increase in Federal Medicaid funds and a decrease of State and county funds, it also became apparent early in our deliberations that shifting costs created the potential for making residents currently in HALs ineligible for SA assistance. (NOTE: The eligibility standard equates to the SA payment level.)The Committee immediately adopted the position to protect this population and ensure that no one was disenfranchised by attempts to better define rates and allocate costs more appropriately between State and Federal dollars.

Policy issues impacting the SA payment for ACH room and board costs were researched for consideration by the Committee and the Department. For purposes of this report, the research is broken into five major issues which are presented below.

Issue 1: Mandatory Minimum State Supplement and Passalong
In 1995, the Congress approved annual cost of living adjustments (COLAs), based on the increase in the Consumer Price Index (CPI), to the Supplemental Security Income (SSI) standard payment amount. In 1977, the Congress mandated that states passalong COLAs to SSI and Social Security beneficiaries receiving mandatory and optional State supplemental payments, and to maintain either a minimum level of payment, or the level of State expenditures under the State's SA Program. In the context of the SA Program, level of payment means an income level or standard representing the approved ACH room and board rate plus a personal needs allowance for the individual's personal needs. Net income is subtracted from the income level to compute the amount of the SA payment for an ACH resident.

Written agreements were required between the states and the Social Security Administration (SSA) as assurance of compliance with these conditions. States' submit an annual compliance report indicating the method by which it complies, i.e., minimum level of payment or total expenditures. North Carolina traditionally uses the minimum level of payment method for compliance but has relied on verbal interpretations from SSA staff on the level of payment it must maintain to meet compliance. Major objectives for the research were:

- Determine what conditions the state must meet to comply with statutory and regulatory requirements for State supplemental payments, and

- Validate that NC is in compliance with the Social Security Act and regulations mandating a minimum level of payment and passalong of COLAs to SSI/State supplement recipients.

Research steps to address the stated objectives included:

- Review of pertinent sections of the Social Security Act and Federal regulations.
- Application of regulations at 20 CFR 416.2096 - .2098 to identify the specific time periods and rules for testing the State's supplemental level of payment.
- Charting by year beginning in 1994 through January 2003 (updated January 2004), the amounts of the SSI benefit rate, annual COLAs, combined SSI and State supplement payment level, maximum State supplement and increases in the State supplement.
- Using the charted amounts and the time periods and rules required by regulation to calculate the minimum level of payment for NC.

Conclusion, Issue 1
The research concluded that North Carolina is in compliance with the mandate for a minimum level of payment and passalong of COLAs. The current $1,084 ACH level of payment exceeds the minimum by over $300. Compliance testing validated the following:

- For the period 7/77 - 3/83, the State's supplemental payment must at least equal the maximum supplemental payment in 12/76, which was $164.20.

  During this period, NC's supplement ranged from $170.60 to $205.70. Annual increases in the amount of supplement equaled or exceeded the amount of the COLAs.

- For the period 4/83 - 1/2004, the combined SSI and State supplemental payment cannot be reduced below the combined level in effect in 3/83 plus subsequent SSI COLAs.

  The combined level in effect in 3/83 was $520.00. Subsequent SSI COLAs through 1/2004 total $279.10. The combined level for 3/83 plus subsequent COLAS equals a minimum level of payment of $799.10 for calendar year 2004.

Issue 2: Options to Prevent Disenfranchisement of Eligible Residents and Protect Medicaid Coverage
The transfers of staff costs for provision of personal assistance to ACH residents and of medically related supply and training costs from the room and board SA rate to the Medicaid PCS rate caused a concurrent decrease in the SA level of payment. In 1995, the SA level of payment was reduced by $173.00. When medical supplies and aide training costs were shifted in October 2002, the level of payment decreased by $51. With each payment level reduction, some SA recipients would have lost financial eligibility for State supplement and automatic eligibility for Medicaid coverage. The General Assembly authorized continued SA payment to these disenfranchised recipients using the SA payment level prior to the cost shift, allowing them to also qualify for Medicaid services.

The search for options to prevent disenfranchisement from the SA Program or the loss of automatic Medicaid coverage was begun soon after formation of the Committee and continued throughout the course of the Committee's work. Research efforts followed up comparisons with other state SA programs referenced in the 2002 Clifton Gunderson study, NC Special Assistance

Rate Methodology and reports that other states had limited the amount of their state supplements and maximized Federal Medicaid funding. The major research objectives were to:

- Gain an understanding of program policies used by other states to provide Medicaid coverage to residents of facilities similar to NC ACH facilities.
- Determine how and by what authority other states provide Medicaid coverage to non-SSI recipients living in residential care facilities,
- Explore methods used by other states to limit their state supplements and maximize federal Medicaid funding, and
- Propose alternatives that would reduce or eliminate disenfranchisement of SA eligibles and protect automatic Medicaid coverage in the event further realignment of costs from SA to Medicaid becomes feasible.

Research of the objectives was approached in several steps. Pertinent sections of the Social Security Act (Titles XVI (SSI) and XIX (Medicaid)) were searched for state latitude in design of their optional SA Programs or the possibility for differing interpretations. Research also involved a reading of the now repealed controlling statute and regulations for administration of pre-SSI State administered assistance programs. From this study, the concept of a Standard of Need and a separate lower Standard of Payment (ratable reduction of need standard used in the Temporary Assistance for Needy Families (TANF) program) was extracted and developed as an alternative for consideration. Conceptually, a non-SSI resident with income below a standard of need meets the income eligibility test and qualifies for automatic Medicaid coverage, however the amount of his state supplement would be determined by the lower standard of payment.

State Medicaid Plans and amendments posted on the CMS website were accessed to learn whether optional coverage groups and financial criteria applied by other states addressed a similar issue. The search included states referenced in the Gunderson Study, states similar in size to NC, states generally considered to be progressive in their Medicaid coverage of needy individuals, and states represented on the Eligibility Technical Advisory Group (E-TAG, a joint State-CMS workgroup). Where available, online administrative rules and policy manuals or handbooks used in the selected states were accessed to research policies for Medicaid coverage of non-SSI recipients living in licensed residential care facilities.

A copy of each state's current approved State Medicaid Plan for optional categorically needy groups and the financial eligibility section of the plans was obtained. This information was used to (1) compile a chart comparing the options for coverage and financial eligibility of the selected states and (2) search for specific regulatory authority supporting the state's interpretations and application of policies.

Following study of written materials, telephone contacts were made with the selected states to discuss program policies providing Medicaid coverage for individuals living in residential care. Discussions centered on non-SSI recipients who do not qualify for a state supplement to pay for room and board.

Brief descriptions of Section 1915(c) waivers posted on the CMS website were accessed and reviewed. Over half the states have approved or pending waivers describing provision of "adult residential care, assisted living, foster care, residential care services", etc. to aged/disabled individuals. Under 1915(c) waivers, non-traditional Medicaid services may be provided in home and community-based living situations to individuals who require the level of care provided in a

medical institution, i.e. a nursing facility or hospital. Use of 1915(c) waivers for their residential care population was discussed with states during the phone contacts. The Standard of Need/Standard of Payment concept was developed and augmented with three case profiles and Medicaid expenditure data for SA residents and for nursing facility (NF) residents. The case profiles represented actual SA Program applicants whose income exceeded the SA payment level by a few dollars and described the effect denial of a state supplement and Medicaid had on their decisions for care. The paper was shared in a face-to-face discussion with CMS officials to obtain feedback and guidance for a solution that provides appropriate levels of care and is less costly to all funding partners than forced admissions to nursing facilities.

Drawing on the policies, administrative rules and State Medicaid Plans of other states and NC General Statutes, options for a $5 minimum guaranteed payment and an income disregard applicable to non-SSI recipients who would otherwise not qualify for a state supplement were developed for consideration. Under the guaranteed minimum payment option, an SA payment of $5 would be issued to non-SSI residents with incomes up to the SA level of payment in effect prior to a reduction related to cost shifting from the room and board cost centers to Medicaid PCS. Receipt of the minimum payment would protect their Medicaid coverage. Under the income disregard option, individuals with income greater than the current SA level of payment would have a limited amount of income disregarded to be used for a specific purpose, making the person eligible for a $1 SA payment.

Conclusions, Issue 2

1. An all inclusive rate, referenced in the Gunderson Study, but not a recommended approach, is best used to gain insight about how regulations have been applied in one state to coordinate non-medical residential care room and board payments with Medicaid PCS payments. Stated simply, survey data and pricing models are applied to establish daily payment rates. Arrayed by 3 geographic areas of the state, the rates include room and board costs and 4 care levels. The state's Medicaid system applies the care level and rate data, subtracts the costs paid by the resident, and reimburses the difference to the licensed residential care facility. SSI recipients use their income to pay only their room and board costs (valued at less than the SSI standard payment). Non-SSI recipients pay room and board costs, and contribute any remaining income to the care cost.

2. Per Diem rates used by another state referenced in the Gunderson Study are not a feasible alternative for NC. A per diem rate for room and board and a per diem rate for medical and remedial care costs are established for each licensed residential facility in the Gunderson study state (400 +), not to exceed a statewide capped rate. Application of this model would be too labor intensive and burdensome to be economical if applied to the 5,000+ licensed facilities in NC. However, this state's policies were instructive for allocation of at least a share of housekeeping, dietary, and laundry service staff costs as reimbursable Medicaid PCS. These services traditionally were considered part of the "room and board" cost, however Medicaid PCS task definitions include light housekeeping, meal preparation and laundry services when authorized for a recipient in his place of residence.

3. Valuable insights were gained about the use of SSI living arrangements and state licensing standards to establish different income standards for State supplemental assistance. Many states have separate SA payment levels for licensed residential care facilities, using licensing criteria to differentiate for type of care/living arrangement or size of facility. This model could have potential in NC, but requires significant staffing and time to develop and implement.

4. CMS disagreed with the Standard of Need/Standard of Payment concept. While they accepted that current Federal laws and regulations have unintended consequences, they interpret the controlling Federal regulation at 42 CFR 435.232 literally. In their view, individuals must have less income than the level of payment or income standard used to determine eligibility and amount of payment, and must actually receive a supplemental payment. CMS recommended protection of Medicaid for non-SSI residents in ACHs through either a 1915(c) waiver or Section 1115 demonstration waiver. CMS staff was noncommittal about NC's chances for getting a Section 1115 waiver approved.

5. The comparison of State Medicaid Plans indicated much similarity in coverage of optional groups of eligibles and financial eligibility. It did not however reveal specific regulatory authority for other States' policies. For instance, a footnoted statement on the bottom of the State Medicaid Plan Attachment (the suggestion of a CMS Regional Office staff member many years ago) was cited as the authority by one state. In another state, administrative rules were adopted based on options allowed by Federal regulations, though no specific Federal regulation was cited. In still another state, the staff knowledgeable about 'Income Standards for Medicaid Only' individuals living in residential care had recently retired. Thus, clear authority to give Medicaid coverage without receipt of a state supplemental payment or waiver authority appears to be ambiguous.

6. The Committee and the Department determined that there are significant drawbacks to either an 1115 or 1915(c) waiver. A Section 1115 demonstration waiver requires lengthy development and approval processes, ongoing evaluations and Federal budget neutrality. Under a Section 1915(c) waiver, the target population must meet the state's criteria for institutional care, i.e. nursing facility or hospital. NC General Statutes, which prohibit ACH facilities from admitting residents who require nursing level of care, would need to be amended.

    - A state's medical need criteria for institutional care may include functional or cognitive limitations as well as the need for medical care. Thus, the ACH resident population could be split between 'waiver' and 'non-waiver'. In addition, PCS for ACH residents eligible under a 1915(c) waiver would have to be defined differently in scope or level of service provision than for non-waiver ACH residents.
    - A primary benefit of a 1915(c) waiver is the option to use 300% of the standard SSI payment as the income threshold for eligibility and to set a different threshold for protection of income to meet the costs for room and board and personal needs. This would allow Medicaid for waiver eligibles with gross monthly income up to $1,692.
    - Neither State nor facility resources are adequate at this time to study how a waiver could be structured, nor to develop the policies, licensing standards or an assessment instrument and process to make the pursuit of waivers a viable alternative.

Issue 3: Definitions Associated with Room and Board and Personal Care

Discussion of research findings associated with State supplemental payments for room and board costs and Medicaid PCS prompted questions from the Committee about the Federal definitions for these terms. The major objectives of the research of definitions of terms were to:

- Determine whether there is a specific or universal definition of room and board under federal laws or regulations governing public assistance programs with Federal oversight and/or financial participation,
- Determine whether there is commonality of the definition of room and board among assistance programs, or states,
- Verify the CMS definition of PCS, and
- Determine what criteria are required by the Internal Revenue Service (IRS) to claim PCS costs as a medical expense deduction for income tax purposes.

Research for definitions used or accepted by CMS and other Federal agencies involved an extensive search of Federal statutes and regulations governing public assistance programs and their administration by states and local governments. In addition, the U.S. DHHS Departmental Appeals Board decisions for over a decade were reviewed to ascertain whether the disputes involved a definition of room and board. Administrative policies for cost allocation and reporting associated with public assistance programs and guidance and interpretations issued in the State Medicaid Manual were reviewed. The online glossary at the CMS website was queried for definitions of "room", "board" and "room and board".

Conclusions, Issue 3
There is no statutory definition for the terms “room,” “board,” or “room and board” and no specific commonly applied written interpretation among the various assistance programs or states administering the programs with the exception of Section 1915(c) waivers. In the context of waivers, and pursuant to 42 CFR 441.310, the term "board" means 3 meals a day or any other full nutritional regimen. Statute and regulations relating to TANF, Foster Care Maintenance, Foster Care Independence, and SSI generally describe these assistance payments as including food, shelter, utilities, household goods, clothing, etc., without defining the terms. The Departmental Appeals Board cases did not involve a definition of room and board.

The CMS State Medicaid Manual (SMM), Section 4480, describes PCS as a range of human assistance to enable persons with disabilities and chronic conditions of all ages to accomplish tasks that they would normally do for themselves if they did not have a disability. Within this general description, states have latitude to define the scope of PCS services included in their State Medicaid Plan, however services must be provided by a qualified provider who is not a member of the individual's family. The SMM references the Federal Medicaid Program definition of family as "legally responsible relatives". It was concluded that NC's scope of services and delivery meets the limited specifications of 42 CFR 440.167 and the SMM guidance.

According to IRS Publication 502 (for tax year 2002), privately paid costs for "qualified long term care services" may be claimed as a medical expenses in figuring the allowable tax deduction. Qualified long term care services must be prescribed by a licensed health care practitioner to a chronically ill individual who is unable for 90 days or more to perform at least 2 activities of daily living without substantial assistance from another individual due to loss of functional capacity and/or requiring substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Issue 4: Conversion from Cost Reporting to a Prospective Payment System
NC currently requires that certain ACH facilities file cost reports on an annual basis. Cost report data is used to set the allowable room and board rate for residents receiving a state supplement to

their own income and to cost settle overpayment of PCS to private facilities. The major objectives of research were to:

- Determine whether other states may have changed from cost reporting to a prospective payment system for provision of PCS in licensed residential care facilities, and
- Explore how the change was explained or justified in the states' Medicaid plan amendment.

Research of Medicaid PCS reimbursement methodologies and a change in methodologies was approached by searching the online Medicaid State Plans at the CMS website. Medicaid Plan Attachment 3.1-A describing "other medical care and remedial care services" covered by selected states was searched to identify whether PCS is a State Plan Service. Attachment 4.19-B, which describes the State's reimbursement methods, was reviewed for the States covering PCS as a Medicaid Plan service to determine whether cost reporting and settlement or a prospective payment system process is used. Additionally, State Plan amendments to Attachment 4.19-B on the CMS State Medicaid Plan page were searched to determine whether any had changed from cost reporting/settlement to a prospective payment system. If the State's Attachment 4.19-B was not specific about reporting and settlement vs. prospective payment system, reimbursement, information was sought via the State's Medicaid website and administrative rules. Due to constraints of time and locating the most knowledgeable state official, phone contacts with the states were not attempted.

Conclusions, Issue 4
The reimbursement methodologies described in the state plans reviewed are worded very generally referencing terms such as, the lower of billed amount or Title XIX maximum charges, hourly unit rate, and upper limit. The state plans did not specify a cost settlement process, nor did they specify a prospective payment system. States' plan amendments during the past two to three years did not indicate any changes in reimbursement methodology for Medicaid PCS. Methods for reimbursement could not be found on the states' websites or administrative rules. The specificity with which NC describes its reimbursement methods in NC Administrative Code and the State Medicaid Plan is unmatched by other states and probably not required.

Issue 5: State Designed SA Program in Lieu of Federally Prescribed Program
No Federal funds are received to support the cash assistance payments for the costs of room and board in a licensed ACH facility. Yet, Federal laws and regulations of the federally prescribed but optional State Supplemental Assistance Program limit the State's flexibility to make SA Program changes that are beneficial to NC taxpayers without jeopardizing Medicaid coverage for ACH residents. This caused the Committee to question the ability of the State to cease providing the federally prescribed optional SA Program and use existing State and local funds to create a State designed optional State supplement with entitlement to Medicaid.

The major objectives of the research effort were to determine whether NC could cease operating the current optional SA Program without penalty, design its own State Supplemental Assistance Program for ACH residents using current State and local funds, and provide automatic entitlement to Medicaid for the State SA Program recipients.

Public Law 93-66 and Section 1618(a) of the Social Security Act were used to answer the question. P.L. 93-66 authorized states to give individuals who applied for SSI and/or Supplemental Assistance after January 1, 1994, access to Medicaid on the same basis as

mandatory state supplement recipients. Section 1618(a) requires states' to sign agreements with the Social Security Administration in which the state agreed to continue to make supplemental payments at levels not lower than the payment level of March 1983, plus all subsequent cost of living adjustments.

Conclusions, Issue 5

The State would jeopardize receipt of federal financial participation in its Medicaid expenditures if the mandated agreement signed with SSA pursuant to Section 1618(a) is broken and the State ceases to operate its optional SA Program under federally prescribed conditions.

Non-SSI SA recipients are automatically entitled to Medicaid only if their gross income does not exceed $1,692. Medicaid is an automatic entitlement without a separate application for cash assistance recipients, otherwise, individuals must file a separate application and be determined eligible.

Recommendations

The mission of the Adult Care Home Cost Modeling Committee—To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to meet resident care needs—requires the coordinated implementation of the following recommendations. While it is recognized that full implementation of these recommendations is subject to availability of funds, rules and legislative changes, and CMS approval, it is also apparent that implementation of only one or two would undermine the achievement of the desired outcomes: improved resident care through assessments and the creation of a more stable ACH workforce and a reimbursement rate that drives those outcomes. Once a decision is made to implement this methodology, a representative group of individuals will be formed to address implementation schedules, appropriate notification, training and policy development.

1. **Adopt the cost model methodology and change existing APA rules and legislation to accept the cost model approach and seek appropriations to fully fund the new approach.** This approach means that direct and indirect cost percentiles would be eliminated along with cost settlement.

2. **Reassess the cost model every 3 years for proper reimbursement.** To ensure that ACHs are reimbursed at levels reflective of the existing cost of living increases and current market rates and regulatory changes, the process for reassessment should be conducted on a routine basis. During the off years from cost modeling, cost reports will still be submitted in order to gather data from facilities to be used for statistical and trend identification purposes.

3. **As part of routine cost modeling and rate setting, study feasibility of allocating costs more appropriately between SA and PCS.**

4. **Improve the screening and assessment processes to promote appropriate placement and quality of care of ACH residents.** Concerns about resident safety and quality of care continue to underscore the need for improvements in the State's screening and assessment processes for ACHs. DMA should take the lead in this by working with other DHHS divisions and building on the experience from nursing facility prior approval programs (including PASARR), the CAP/DA automated assessment program, the SA In-Home Program automated assessment, and the electronic FL-2e systems.

5. **Ensure that any Division of Facility Services (DFS) regulatory changes with the potential to impact rates are reflected in the cost model.** As the regulatory authority for ACHs, DFS performs initial licensure surveys and inspections of problem facilities and creates rules for ACHs. In this capacity, DFS has the potential to impact the cost of operations within an ACH. Adapting the cost modeling methodology will require that proposed regulatory changes are "run through the model" so that the fiscal impact can be determined and presented to the DHHS Rate Setting Review Board prior to implementation.

6. **Monitoring & Performance Expectations—DFS, DHHS Office of the Controller, and DHHS Office of Internal Audit—**Continued ongoing monitoring by DFS to ensure that ACH facilities are providing care according to written performance expectations; by the Rate Setting Section of the DHHS Office of the Controller to ensure that ACHs are utilizing the increased funding to benefit direct care salaries; and random audits by the DHHS Office of Internal Audit to verify the rate increases are reflected in the direct care component of cost reports. Once these recommendations are fully implemented, performance expectations will be developed.

7. **Reimbursement modeling should account for resident mix and facility size.** Facilities are reimbursed a single SA rate for residents regardless of special needs or size of the facility. The reimbursement model should differentiate between the traditional ACH resident and those in SCUs to reflect the higher staffing need of SCUs. In addition, to the extent that this can be accomplished, the reimbursement system should reflect the different costs associated with types of facilities based on population served and the staffing levels required. Over the longer term, the reimbursement should be matched to the resident's needs. As the adult care homes become proficient in the use of assessments and automation, reimbursement systems can become more sophisticated and similar to case mix systems used in nursing facilities. Such changes will require rules and legislative modifications.

8. **Develop similar modeling for Family Care Homes and Mental Health Group Homes.** The rate paid to Family Care Homes is to be "based on market rate data." It is obvious from the results of the modeling conducted for ACHs that a similar process needs to be followed for other categories of facilities.

9. **The Department should adopt an income disregard policy to prevent disenfranchisement of ACH residents from financial eligibility for SA and Medicaid**. As cost modeling is performed, evaluate potential for shifting costs for housekeeping, dietary and laundry services directly related to resident personal care needs to Medicaid. Implementing an SA Income Disregard will require the following steps and could become effective, subsequent to approval by the General Assembly and CMS, within one year, preferably in October when any new SA rate is routinely implemented. The SA Income Disregard will allow a disregard of income in determining SA eligibility. The amount of the disregard, which will be up to the amount of reduction in the SA payment level as a result of shifting costs for Medicaid covered services from SA to the Medicaid program, will be used by the SA recipient to pay for a portion of the costs of the PCS services covered by Medicaid. This Income Disregard will prevent ACH residents from losing their current SA eligibility due to further cost shifts from SA to Medicaid.

    a. Obtain departmental approval of the EIS (Eligibility Information System) "Track Record."

    b. Submit EIS "Track Record" change request to the Division of Information Resource Management (DIRM) so that priority can be assigned and resources allocated. For a change in a case to be effective in EIS for a specific month, the data must be entered in EIS during the previous month.

    c. Prepare legislation to authorize the SA income disregard and its application to the cost of PCS provided to SA recipients by the ACH.

d. Submit Medicaid State Plan amendment to CMS for approval. (This will require 2 year fiscal estimate.)

e. The Division of Medical Assistance (DMA) and Electronic Data Systems (EDS) staff must determine process for manually reducing payment to ACHs for PCS provided to SA recipients with the income disregard and whether it will require any Medicaid Management Information System (MMIS) changes. Any necessary MMIS changes must be in production by whatever target date claims from ACHs for PCS provided will be received.

f. Prepare SA Manual revisions. Counties must have the policy in-hand no less than thirty days prior to implementation. An earlier date for manual revisions is desirable to support training.

g. Conduct training of county staff in new SA income disregard policy. Conduct training sixty days prior to implementation of the new income disregard policy.

Recommended ACH Program Enhancements
(Estimated 30 Month Work Plan)

ACH Enhancement	Tasks and Estimated Target Date for Completion	Comments
Mental Health Screening Program for Medicaid/SA recipients	• Design a process for screening residents for mental health needs prior to admission by March, 2005 • Identify resources/funds for screening program by September, 2005 • If determined that this is the best option, develop RFP and award contract for implementing a mental health screening program by March, 2006	Report due from First Health on the Mental Health Screening Project no later than July 31, 2004. RFP development and contract award process is taking approx. 6 months.
Assessment and care planning instrument for Medicaid and SA recipients residing in ACH's.	• Develop and finalize a new assessment and care planning tool by June, 2005 • Run pilot test of the paper tool from July, 2005 through Sept., 2005 with selected facilities • Determine/allocate resources needed to implement assessment and care planning system (state resources and provider resources) by Sept., 2005 • If determined that this is the best option, develop RFP for a contractor to design an interactive web site to allow ACH providers to access the tool and submit resident information into a searchable database. RFP developed by December, 2005 • Contract could possibly be awarded by Feb., 2006 • Contractor will require 6 months to design system – Aug, 2006 • If above schedule is achievable, conduct Statewide training by Dec., 2006 and quarterly in regions thereafter • Statewide implementation by April, 2007	Tool should be based on the MDS (Minimum Data Set)
Medical and Functional Criteria (level of care) for New Admissions to ACH's	• Draft of Medical and Functional Criteria by April, 2005 • Finalize Medical Criteria and review as medical policy by July, 2005 • Post medical policy for public review by Aug., 2005	Consider separate criteria for the different types of facilities (particularly family care homes). Must be coordinated with DFS rules.
New Screening/Admission Tool Reflecting the ACH level of care criteria	• Develop prior approval screening tool (revised FL2/FL2e) to be used with the medical criteria for admission to an ACH by March, 2005 • Statewide training on new screening tool and new criteria Aug-Oct. 2005 • Develop with automation capability and link to new MMIS prior approval system – To be determined	This tool could use a scoring system of ADL's to determine if the person meets minimum criteria for admission. The approving authority will need to know the criteria for admission and apply consistently to all Medicaid admissions. Process for admission would be coordinated with Mental Health Screening Program. DMA is currently testing the automated FL2e – and a scoring system for ADL needs. Screening tool development and implementation need to be considered in the context of other long term care

		options.
Utilization Management and Quality Assurance Program to have some assurance that persons are placed appropriately in the ACH and that services are being provided based on individual care needs.	• Design utilization management and quality assurance program by June 2006 • Develop RFP to contract for a new utilization management and quality assurance program by November, 2006 • Develop standards and protocols and report requirements for a UM program by November, 2006 • Target date for implementation of UM and QA program for ACH's: July, 2007	Ideally, the utilization management and quality assurance program would be operated by the same entity that designs and operates the assessment system and searchable database. The UM program should only be implemented after the statewide implementation of the new assessment tool. A UM and QA program will consist of multiple levels of review and monitoring. State level support systems will need to be developed and well planned.

Prepared by:
Division of Medical Assistance
October 19, 2004

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Lanier M. Cansler, Deputy Secretary

MEMORANDUM

TO: Adult Care Home Cost Modeling Committee Members

FROM: Lanier M. Cansler

DATE: October 22, 2002

SUBJECT: Adult Care Cost Modeling Committee

As you are aware, the Department currently performs rate setting for the payment of State County Special Assistance (SCSA), Medicaid Personal Care Services (PCS) and Medical Transportation. Separate rate setting methodologies are employed by the Department in establishing the rates for all three types of service. In an effort to ensure that we are adequately addressing the cost of providing services to our clients who reside in domiciliary type facilities (inclusive of Family Care Homes, Homes for the Aged, Mental Health Facility, Nursing Homes and Mental Health Facilities) we are establishing a committee to consider the potential for development of a consistent costing methodology that could be utilized across each of the three programs considering the full cost of operating these type facilities in a consistent and defensible manner.

I have asked Sandra Trivett and Gary Fuquay to co-chair a committee made up of staff from Division of Social Services, Division of Medical Assistance, Division of Facility Services, Office of Policy and Planning, Controller's Office, Office of Internal Audit, Office of Long Term Care and Adult Care industry representatives. You have been selected by your director to serve on the committee. Sandra and Gary will notify you of the first meeting of the committee.

CC: Lynda McDaniel
Jim Bernstein
Pheon Beal
Nina Yeager
Bob Fitzgerald

Committee Members:
Lou Wilson
Jerry Cooper
Craig Souza
Gary Fuquay
Dan Stewart
Sandra Trivett
Alene Goolsby
John Tanner
Suzanne Merrill
Lynne Perrin
Dave Mosley
Jim Panton
Curtis Crouch
Pat Jeter
Doug Barrick
Jim Upchurch

Members

Adult Care Home Cost Modeling Committee

Gary Fuquay, Co-Chair, Director, DHHS, Division of Medical Assistance

Sandra Trivett, Co-Chair, DHHS Office of Policy and Planning

Doug Barrick, DHHS, Division of Facility Services

Paul Cole, DHHS Office of the Controller

Jerry Cooper, Executive Director, NC Assisted Living Association

Curtis Crouch, DHHS, Office of the Controller

Jeanne Duncan, North Carolina Support Providers Council

Stacy Flannery, North Carolina Health Care Facilities Association

Jackie Franklin, DHHS, Division of Medical Assistance

Alene Goolsby, research consultant, formerly with the Division of Medical Assistance

Bruce Habeck, DHHS Division of Medical Assistance

Lisa Haire, DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Pat Jeter, DHHS, Division of Medical Assistance

Deborah Landry, DHHS Division of Budget & Analysis

Lynda McDaniel, DHHS, Assistant Secretary for Family Services and Long Term Care, *since retired*

Suzanne Merrill, DHHS, Division of Aging and Adult Services

June Montgomery, DHHS, Office of the Controller

Jim Panton, DHHS, Division of Medical Assistance, *since retired*

Lloyd Pattison, DHHS, Division of Medical Assistance

Lynne Perrin, DHHS, Division of Medical Assistance

Dave Peterson, formerly with the DHHS, Division of Mental Health *(now with Wake County)*

Barbara Ryan, DHHS*,* Division of Facility Services

Jackie Sheppard, DHHS, Assistant Secretary for Family Services and Long Term Care

Joe Slaton, DHHS Division of Budget & Analysis

Phillip Tarte, DHHS Office of Policy and Planning

Dan Stewart, DHHS Internal Auditor

John Tanner, DHHS, Division of Social Services, *since retired*

Jim Upchurch, DHHS, Division of Facility Services, *since retired*

*Andy Wilson,*DHHS*,* Division of Medical Assistance

Lou Wilson, Executive Director, NC Association, Long Term Care Facilities

May 24, 2004

Adult Care Cost Modeling
Short and Long Term Approach

PURPOSE STATEMENT: Develop a comprehensive rate setting methodology for Adult Care that encompasses all funding streams provided by DHHS.

Short Term Goals	Actions/Notes	Contact(s)	Finish Date
1. Based upon the current regulatory staffing requirements:			
a. Select a representative sample of at least 3 facilities having clients receiving SA that are considered by DHHS and the industry to be quality providers with efficient operations. (Determine facility sample by geographic orientation, size of facility, Mental Health licensed, SCU's, HAL, SA/Private pay mix, 80% occupancy and other criteria as appropriate.	a. Facilities were selected, solicited, trained and submitted cost reports as requested		9/04
b. Perform an acuity analysis of the clients in the sample.	b. Assessments were completed by RN's in a contract with Home and Hospice Association – in two phases. Myers & Stauffer conducted the analysis of information and prepared final report in May		8/03
2. Based on cost reports and the current staffing requirements:			
a. Perform a staffing analysis of time and effort taken to provide appropriate levels of care to the population in the selected facilities using the RUGS criteria.	a. Industry provided their requirements to care for the client base. Based on their information, the current regulations, and the acuity of clients, M&S completed a staffing analysis for facilities.	Curtis Crouch	5/04
b. Develop a staffing model from the above analysis. (Actual needs gathered from industry input would need to be used for three areas in which standard staffing requirements/overall costs do not exist: Housekeeping, Food Service/Dietary and Medication Administration.)	b. A subgroup convened to discuss and clarify the different FTE's (Nurses, NA's and CNA's) performing most tasks in ACH's and how to adjust for the fact that M&S comparison data was based on RN level of care. The subgroup included: Lynne Perrin, Lou Wilson, Jerry Cooper, and Curtis Crouch. They met Monday, April 19, 2004, to address this issue and reported their results to the committee in late April.	Lynne Perrin	4/04

Short Term Goals	Actions/Notes	Contact(s)	Finish Date
3. Identify any changes needed to the current cost reporting format for Adult Care Homes.	Adopt the cost model methodology but continue to require HAL facilities to submit portions of the existing cost reports to obtain statistical information	Curtis Crouch	9/04
4. Coverage Changes a. Work with Myers & Stauffer in coordination with DHHS divisions to research additional direct costs (i.e. Health Services) to be covered by Medicaid for services provided in Adult Care Home other than the current PCS and Medical Transportation. b. Review service definitions to understand differences between PCS provided in a facility compared to PCS provided in a private home. (Approval from CMS for service definition changes) c. Determine the fiscal impact on SA rates changes. d. Determine if SA rate changes cause disenfranchisement for existing and future eligibles..	a. Identified items for possible cost shifting. Have not gone further due to disenfranchising issues. b. Complete c. Alene Goolsby and Jackie Franklin Both provided information for this population. Curtis Crouch and Hank Bowers brought estimates to the August and September meetings. d. Alene Goolsby has provided the group with much research. Goal of Cost Modeling Committee is to ensure disenfranchisement does not occur. A subgroup will develop an action plan for future eligibles.	a. Committee b. Lynne Perrin c. Curtis Crouch and Hank Bowers d. Alene Goolsby, Suzanne Merrill and Andy Wilson	8/04 4/03 8/04 9/04
5. Begin discussion of how DHHS plans to address capital assets as a component of cost reimbursement. Explore options that will provide an equitable approach to reimbursing owners for cost of facilities while recognizing associated mortgage costs and/or owner investment.	Internal Audit coordinated this effort. The information for all model facilities was entered into a cost report for discussion at a late April meeting. Historical data was gathered from samples of the 3 facility sizes for comparison to the new suggestions being proposed. The information was presented to the full committee in May.	Dan Stewart	5/04
6. Discuss elimination of current reimbursement methodology to a Prospective payment system.	DHHS ready to proceed when assessment tool is in place. Industry asked for delay in implementation until final results of staffing analysis and other recommendations are made.	Committee	9/04

Long Term	Actions/Notes	Contact	Finish Date
1. Based on resident assessments of all clients residing in Adult Care Facilities, remodel to accommodate the staffing needs for each designated level of care/licensed type facility.	Study completed and results presented by M&S on May 13.	Lynne Perrin	5/04
2. Continue regular review of changes in definitions and rates by DMA.	On-going DMA rate setting.	Pat Jeter	ongoing

ADULT CARE COST MODELING

SELECTED INFORMATION ON HAL MODEL FACILITIES

FACILITY	LOCATION	NUMBER OF BEDS	NUMBER OF AVAILABLE DAYS	OCCUPANCY PERCENT	SA PERCENT	TOTAL FTEs BEFORE MODELING	TOTAL FTEs AFTER MODELING	INCREASE IN DIRECT & PCS FTEs	INCREASE IN INDIRECT FTEs
31 - 60 Beds									
The Little Flower	Mecklenburg	49	16,790	99.20%	14.55%	19.98	35.57	14.56	0.90
Burnette's Retirement Village	Franklin	60	21,900	88.48%	91.56%	23.76	32.72	8.96	0.00
Country Club Prime Time	Wake	60	21,900	82.00%	99.98%	25.12	35.87	7.85	1.75
McDowell Assisted Living	McDowell	54	19,710	100.00%	88.52%	22.93	34.52	10.05	1.40
The Canterbury House	Person	60	21,900	79.97%	58.94%	23.19	35.58	9.69	1.68
61 - 90 Beds									
Union Park	Union	87	28,047	89.90%	54.03%	30.67	46.81	14.14	1.02
Meadows of Laurinburg	Scotland	80	29,440	91.28%	91.13%	36.98	47.11	9.45	0.51
Homeplace	Durham	71	25,915	90.90%	81.66%	29.00	40.92	9.93	1.05
Reynolda Park	Forsyth	72	22,052	93.66%	49.95%	25.02	41.04	13.67	0.40
Davie Place	Davie	69	25,185	76.06%	86.00%	24.97	35.14	10.17	0.00
91+ Beds									
First Assembly	Cabarrus	180	65,700	81.89%	78.63%	60.27	83.84	20.57	0.00
Greensboro Place	Guilford	93	33,580	94.10%	59.91%	34.79	52.90	16.32	1.16
Meadows of Mount Olive	Wayne	104	38,272	89.57%	77.36%	42.88	55.16	11.71	0.57
Meadows of Greenbrier	Robeson	104	38,272	80.92%	88.42%	42.23	55.95	13.04	0.19

ADULT CARE COST MODELING

SELECTED INFORMATION ON SCU MODEL FACILITIES

FACILITY	LOCATION	NUMBER OF BEDS	NUMBER OF AVAILABLE DAYS	OCCUPANCY PERCENT	SA PERCENT	TOTAL FTEs BEFORE MODELING	TOTAL FTEs AFTER MODELING	INCREASE IN DIRECT & PCS FTEs	INCREASE IN INDIRECT FTEs
Twelve Oaks	Surry	43	15,695	97.35%	57.32%	33.23	34.71	0.87	0.56
Greensboro Place	Guilford	25	8,395	95.81%	24.32%	18.14	38.09	18.90	0.65
DP @ Concord Place	Cabarrus	25	9,125	83.73%	44.08%	15.07	25.15	8.68	0.50
Carillon Assisted Living	Gaston	24	8,760	86.53%	6.03%	8.43	23.00	14.57	0.00
Carolina House of Smithfield	Johnston	24	7,968	95.61%	28.55%	14.62	25.46	9.36	0.65
DP @ High Point Place	Guilford	65	23,508	75.27%	34.81%	35.62	39.27	1.65	1.00
DP @ Statesville Place	Iredell	40	14,600	95.29%	21.87%	28.52	38.61	7.50	1.61
Gastonia Village	Gaston	48	16,790	82.25%	65.00%	16.31	40.50	21.59	1.60
DP @ Burlington Manor	Alamance	52	18,980	95.74%	36.97%	32.85	42.29	7.24	1.50

ACH Cost Modeling - Rate Proposal for all Selected Non-SCU HAL Licensed Facilities

	SA Direct Costs						
	Housekeeping & Laundry	Dietary	Recreational Activities	**Total**	**Resident Days**	**Direct per Resident Day**	**Direct per Resident Month**
Burnette's Retirement Village	$105,506	$163,044	$14,508	**$283,058**	**19,372**	**$14.61**	**$444.44**
McDowell Assisted Living	$100,901	$169,297	$43,802	**$314,000**	**19,710**	**$15.93**	**$484.57**
The Little Flower	$66,780	$165,171	$111,135	**$343,086**	**16,655**	**$20.60**	**$626.57**
The Canterbury House	$60,551	$150,479	$47,678	**$258,707**	**17,513**	**$14.77**	**$449.32**
Country Club Prime Time	$69,569	$160,988	$47,186	**$277,743**	**17,958**	**$15.47**	**$470.43**
Meadows of Laurinburg	$75,824	$212,537	$25,636	**$313,998**	**26,872**	**$11.68**	**$355.42**
Reynolda Park	$63,323	$233,318	$68,579	**$365,220**	**20,654**	**$17.68**	**$537.85**
Union Park	$67,640	$246,086	$66,275	**$380,001**	**25,215**	**$15.07**	**$458.39**
Davie Place	$47,482	$108,722	$39,980	**$196,185**	**22,697**	**$8.64**	**$262.91**
Homeplace	$77,128	$261,241	$41,001	**$379,371**	**23,556**	**$16.11**	**$489.86**
Greensboro Place	$76,647	$265,349	$74,001	**$415,997**	**31,599**	**$13.16**	**$400.43**
Meadows of Greenbrier	$97,034	$261,405	$25,989	**$384,428**	**30,972**	**$12.41**	**$377.54**
First Assembly	$228,149	$785,230	$48,226	**$1,061,605**	**53,805**	**$19.73**	**$600.14**
Meadows of Mount Olive	$98,489	$261,364	$28,120	**$387,973**	**34,280**	**$11.32**	**$344.25**
Total	**$1,235,024**	**$3,444,232**	**$682,116**	**$5,361,371**	**360,858**	**$14.86**	**$451.91**

ACH Cost Modeling - Rate Proposal for all Selected Non-SCU HAL Licensed Facilities

	SA Indirect Costs						
	Property Ownership and Use	Operations and Maintenance	Administration Allocation	**Total**	**Resident Days**	**Indirect per Resident Day**	**Indirect per Resident Month**
Burnette's Retirement Village	$196,970	$95,475	$64,463	**$356,908**	**19,372**	**$18.42**	**$560.39**
McDowell Assisted Living	$118,790	$55,321	$132,746	**$306,857**	**19,710**	**$15.57**	**$473.54**
The Little Flower	$181,068	$78,440	$80,848	**$340,356**	**16,655**	**$20.44**	**$621.59**
The Canterbury House	$285,667	$82,843	$82,650	**$451,160**	**17,513**	**$25.76**	**$783.58**
Country Club Prime Time	$185,562	$80,263	$82,586	**$348,411**	**17,958**	**$19.40**	**$590.13**
Meadows of Laurinburg	$463,260	$98,205	$127,261	**$688,726**	**26,872**	**$25.63**	**$779.57**
Reynolda Park	$363,224	$103,530	$168,617	**$635,372**	**20,654**	**$30.76**	**$935.70**
Union Park	$465,304	$122,735	$187,456	**$775,496**	**25,215**	**$30.76**	**$935.47**
Davie Place	$355,555	$82,925	$90,666	**$529,145**	**22,697**	**$23.31**	**$709.12**
Homeplace	$268,864	$119,433	$126,455	**$514,752**	**23,556**	**$21.85**	**$664.67**
Greensboro Place	$497,122	$133,816	$180,228	**$811,166**	**31,599**	**$25.67**	**$780.81**
Meadows of Greenbrier	$439,588	$91,746	$113,668	**$645,002**	**30,972**	**$20.83**	**$633.44**
First Assembly	$478,173	$266,666	$102,735	**$847,574**	**53,805**	**$15.75**	**$479.14**
Meadows of Mount Olive	$328,760	$138,795	$122,425	**$589,980**	**34,280**	**$17.21**	**$523.49**
Total	**$4,627,907**	**$1,550,193**	**$1,662,805**	**$7,840,904**	**360,858**	**$21.73**	**$660.91**
				SA Totals		**$36.59**	**$1,112.82**
				Capital Cost Adjustment			**$11.16**
				SA Total			**$1,123.98**

ACH Cost Modeling – Rate Proposal for All SCU Bed Facilities Combined

	SA Direct Costs						
	Housekeeping & Laundry	Dietary	Recreational Activities	**Total**	**Resident Days**	**Direct per Resident Day**	**Direct per Resident Month**
Carolina House of Smithfield	43,402	123,948	75,035	**$242,384**	**7,618**	**$31.82**	**$967.78**
Concord Place & Discovery Prog	56,256	100,963	65,642	**$222,861**	**7,640**	**$29.17**	**$887.26**
Twelve Oaks	59,351	88,242	31,176	**$178,769**	**15,279**	**$11.70**	**$355.89**
Greensboro Place (SAL)	67,742	92,216	66,261	**$226,220**	**8,043**	**$28.13**	**$855.51**
Carillon Assisted Living of Crame	53,267	65,192	15,259	**$133,719**	**7,580**	**$17.64**	**$536.58**
Gastonia Village (SAL)	102,089	187,455	89,180	**$378,724**	**13,810**	**$27.42**	**$834.14**
DP @ High Point Place (SAL)	73,983	210,565	67,057	**$351,605**	**17,694**	**$19.87**	**$604.42**
DP @ Burlington Manor (SAL)	86,848	188,787	65,018	**$340,653**	**18,172**	**$18.75**	**$570.19**
DP @ Statesville Place (SAL)	83,486	191,579	67,602	**$342,667**	**13,912**	**$24.63**	**$749.19**
Total	**626,424**	**1,248,947**	**542,229**	**2,417,601**	**109,748**	**$22.03**	**$670.04**

	SA Indirect Costs						
	Property Ownership and Use	Operations and Maintenance	Administration Allocation	**Total**	**Resident Days**	**Indirect per Resident Day**	**Indirect per Resident Month**
Carolina House of Smithfield	110,110	52,582	60,632	**$223,324**	**7,618**	**$29.32**	**$891.68**
Concord Place & Discovery Prog	115,916	47,916	39,310	**$203,143**	**7,640**	**$26.59**	**$808.76**
Twelve Oaks	215,804	62,634	32,665	**$311,103**	**15,279**	**$20.36**	**$619.33**
Greensboro Place (SAL)	109,020	41,418	30,521	**$180,959**	**8,043**	**$22.50**	**$684.34**
Carillon Assisted Living of Crame	59,905	32,824	46,657	**$139,386**	**7,580**	**$18.39**	**$559.32**
Gastonia Village (SAL)	216,128	87,425	148,322	**$451,875**	**13,810**	**$32.72**	**$995.26**
DP @ High Point Place (SAL)	342,914	99,271	173,190	**$615,375**	**17,694**	**$34.78**	**$1,057.85**
DP @ Burlington Manor (SAL)	226,487	97,348	113,609	**$437,444**	**18,172**	**$24.07**	**$732.20**
DP @ Statesville Place (SAL)	220,474	85,613	140,959	**$447,046**	**13,912**	**$32.13**	**$977.40**
Total	**1,616,758**	**607,031**	**785,866**	**3,009,655**	**109,748**	**$27.42**	**$834.13**
						$49.45	**$1,504.16**
				Capital Cost Adjustment			**$11.16**
				SA Totals			**$1,515.32**

Cost to Fully Implement the Adult Care Home Cost Model Summary of Funding Requirements				
	Total	**Federal**	**State**	**County**
SCSA*	**$9,980,260.00**	**$0.00**	**$4,990,130.00**	**$4,990,130.00**
PCS**	**$188,854,207.00**	**$120,167,932.00**	**$50,152,255.00**	**$18,534,020.00**
Breakout:				
HAL	$180,096,959.00	$114,595,695.00	$47,826,674.00	$17,674,590.00
SCU	$8,757,248.00	$5,572,237.00	$2,325,581.00	$859,430.00
Total	**$198,834,467.00**	**$120,167,932.00**	**$55,142,385.00**	**$23,524,150.00**

NOTE: The success of the Cost Model Approach is dependent upon new program efforts to enhance resident assessments. This will require systems and staffing costs outlined in Attachment 7 which follows.

* **SCSA** dollar figures represents the cost of increasing staff salaries and benefits to the national average based on those necessary for our current clients, which equates to the SA rate raising to $1124 from $1084 per month for Non-SCU clients and to $1515 from $1084 per month for SCU clients.

** **PCS** dollar figure represents the additional cost to the state for its currents clients if we fully fund the needed PCS hours identified with the study of the clients in the homes. Currently the state only pays for 1.1 hours of personal care services to the clients per day. The study by Meyers & Stauffer indicated that the average clients in a non-SCU bed requires 2.31 hours of personal care services per day and a SCU bed client requires 4.07 hours of personal care services per day.

Cost to Implement an Income Disregard				
	Total	**Federal**	**State**	**County**
Income Disregard***	**$22,660,113.00**	**$14,411,910.00**	**$6,335,278.00**	**$1,912,925.00**

*** **Income Disregard** dollar figures represent projected PCS cost for maintaining SA and ACH PCS eligibility for residents if costs are shifted from SA to ACH PCS *independent* of implementation of the Cost Model Approach. An income disregard will prevent disenfranchisement of SA residents and residents who would have been eligible for SA and ACH PCS except when a reduction in the SA rate occurs due to a shift of costs to ACH PCS.

Enhancements to Adult Care Home Services
Estimated Costs

Program Enhancement	Developmental Costs/Year 1	Ongoing Operations	Based on:
Automated Screening/Admission Tool that combines assessment and care planning based on medical, mental health, and functional needs			
Automated Assessment Instrument	$ 100,000.00	$ -	Estimate based on AQUIP costs
Systems Development/Testing/Modifications, etc. **(1)**	$ 550,000.00	$ -	Estimate based on AQUIP costs
Systems Maintenance/Enhancements/Modifications	$ -	$ 250,000.00	Estimate based on AQUIP costs
Quarterly Agency/Provider Training	$ -	$ 48,000.00	$12,000 per quarterly session
DMA Staff	$ 200,000.00	$ 200,000.00	Two consultants, one support, fringe, computers, etc.
Prior Approval System with Automated FL2	$ -	$ 168,000.00	6,000 prior approvals by fiscal agent at $28.00
Contract Mental Health Screenings/Level I	$ -	$ 168,000.00	6000 evaluations at $28.00
Contract Mental Health Scrrenings /Level II	$ -	$ 270,000.00	1000 evaluations at $270.00
Contracted QA/UR Reviews	$ -	$ 240,000.00	$20,000 per month X 12 months
TOTAL	**$ 850,000.00**	**$ 1,344,000.00**	

Notes:

(1) Includes systems development, DMA staff training, in-house testing pilot project with selected agencies, and final modifications after pilot progam.

(2) Significant savings could be realized by contracting with one organization for all assessments and reviews.

North Carolina Department of Health and Human Services

Adult Care Home
Capital Cost Reimbursement Study
Position Paper
May 2004

Adult Care Cost Modeling Committee
Prepared by the Office of the Internal Auditor

Overall Objective of Capital Cost Component Reimbursement

The purpose of this document is to summarize and present alternative methodologies available in the determination and treatment of the Facility Capital
Component of an Adult Care Home Cost Model to achieve the following objectives.

- **Equitable Return on Investment.** The primary objective is to provide a recommendation for the most equitable and feasible alternative. This includes an equitable and fair return to each facility owner, without regard to the capital structure of that owner's business and without affecting the owner's normal business decisions regarding depreciation, rent, improvements and/or repairs.
- **Minimize Costs.** Secondary to this process is that the methodology should seek to minimize the administrative costs associated with capital reimbursement.
- **Process Simplification.** A third objective is the simplification of the process in order to facilitate a better understanding of the program by the public, the legislature, facility owners and investors.

Background and Challenges

Although the objective of the Capital Cost Modeling Subcommittee is to analyze and identify an equitable and feasible capital reimbursement alternative, there are hurdles to overcome since considerations regarding the capital cost component can be complex. For example, considerations involve issues such as:

- Historical (Actual) Construction Cost
- Depreciation methods
- Financing/mortgage Costs
- Major Repairs/Renovations and Capitalization Policies
- Equipment – Fixed versus Moveable
- Geographical Considerations versus "One size fits all"
- Metropolitan vs. Rural Construction Costs
- Metropolitan vs. Rural Land Costs

- Leased or Rented Facilities
- Disposal Gains/Losses
- Excess Bed Capacity
- Facility Size
- Fair Market Rental Value considerations
- Property Taxes
- Insurance

There are several challenges relating to capital costs:

- Facility administrative time and costs involved in capturing, compiling and reporting the cost data
- State administrative time and costs involved in analyzing and auditing the data reported
- Issues pertaining to equitable reimbursements

Historically, these factors have resulted in increased administrative burdens, primarily accounting considerations for both the provider and the State program administrators. Because of these burdens and other considerations, a number of other States have considered alternatives. As noted in the following report section, an increasing number of States are trending to a form of fair rental reimbursement for facility reimbursement. Fair rental has the advantage of being equitable and can be simpler to administer than flat rate or cost-based systems.

Capital Environment in Other States

A Study produced by Myers & Stauffer, LC in 1998 for the State of Washington, Department of Social and Health Services addressed the issue of ***Medicaid Property Payment Study – Comparison of Property Payment Systems in Other States***. While this study addressed Medicaid nursing facility property reimbursement methodologies, the issue regarding capital facility reimbursement is equally relevant to the adult care home industry. Thus, the Washington Study provides valuable insights into various methodologies in reimbursing facilities for the capital component.

The firm of Myers & Stauffer, LC researched and prepared a comparative review of practices in other states and found a great deal of variation in how States reimburse capital costs. The study points out that because of the relative fixed nature of capital costs, these capital costs are more often segregated from normal operating expenses and reimbursed separately. Capital costs are typically defined as depreciation, amortization, lease, mortgage interest expenses, but may include other related expenses such as property taxes and property insurance. Capital costs can also be rent paid to another facility owner. Clouding these different forms of capital costs are transactions/expenses with related parties. For example, the rent/lease or mortgage interest expense may be paid to an affiliated organization (i.e. common ownership interest), and may not be an "arm's length" transaction. Thus, costs incurred and reported may not be the same as a similar transaction conducted by unrelated parties.

The Myers & Stauffer Study broadly separates methodologies into four categories:

1) Flat Rate
2) Cost Based
3) Fair Rental
4) Blended

There are advantages and disadvantages to each of the four categories as enumerated below.

Capital Cost Reimbursement Alternatives - Pros and Cons

Methodology	Advantages	Disadvantages
Flat rate	• Administrative ease • Least opportunity to manipulate costs	• Disincentive for new facility investment • Disincentive for maintenance of existing facilities
Cost based	• Relatively easy to administer • More closely related to provider's actual costs • Easy to understand and communicate	• Require accurate cost data • Encourage manipulation of costs
Fair Rental	• Reward for long term program participation • Recognize owner's equity • Opportunity for capital accumulation to fund improvements • Less subject to manipulation	• Can be administratively cumbersome for property evaluations • Need for periodic appraisal updates
Blended	• Has the advantages of both the cost based and fair rental methodologies, i.e. ease of administration, recognizes owner's equity, etc.	• Has both the disadvantages of cost based and fair rental systems, i.e. can be administratively cumbersome, requires periodic evaluations, subject to manipulation, etc.

Capital Cost Reimbursement Alternatives - pros and cons

Historical Facility Reimbursement in North Carolina

Adult Care Homes have historically been reimbursed on a single state-wide rate. The basis for the rate has been audited cost reports filed by the various facilities. Pre-defined cost report templates with cost centers are completed, audited and submitted to the DHHS Controller's Office. The cost information is entered into a DHHS database, costs are consolidated, sorted (arrayed) by Direct Costs and Indirect Costs. (The Indirect Cost component contains administrative and capital costs.)

The State's formula for computing a state-wide rate has typically been to select the 75th percentile for Direct Costs and 60th percentile for Indirect Costs. The sum of these two percentiles is included in the data provided to the N.C. General Assembly for funding consideration.

Shortcomings. There are a number of shortcomings in the current system such as the following:

- **Cost of Capital.** There is no recognition of the cost of capital. For example, mortgage interest is recognized as operating costs for a facility that is built and financed 100%. On the other hand, an identical facility that is built with an owner's capital (neither borrowings nor mortgage interest) does not reflect any mortgage interest expense. Thus, there is no recognition of owner equity in the present system. There can be a dramatic difference in operating costs for the two otherwise identical facilities.
- **Ownership changes** produce disparities. For example, two identical facilities are built. One is sold ten years later at 250% of the original construction costs. The operating costs (depreciation and mortgage expense) for the new owners is much greater than the facility that was not sold—even though the facilities are physically and operationally identical.
- **Capitalization Policies.** State and Federal tax rules regarding capitalization policies influence decisions on whether to expense or capitalize major repairs or leasehold improvements.
- **Geographical Differences**. Currently, there is no recognition for geographical cost-of-living disparities. For example, a facility in the city of Charlotte receives the same

reimbursement as a facility in Chowan County which has a much lower labor rate that factors into both capital and operational costs.

These are some of the inequities produced by the current system. However, a couple of the main issues are that the current cost reimbursement process does not recognize owner's equity and facility capital costs are subject to wide fluctuations.

Cost Analogy

The fair price for a bed in an Adult Care Home is conceptually not that different from the fair price for a bed in a motel or other lodging establishment. The person renting the bed does not generally consider the costs that have been incurred by the developer/ builder/ owner of the motel. Likewise, the renter is not interested in how much, if any, mortgage interest is being incurred for the property or the cost of repairs for the past year. Instead, the "renter" is looking for a "fair price" considering the location and quality of services offered.

Fair rental reimbursement systems similarly do not consider historical costs, mortgage interest or other cost accounting data. Instead, a fair rental reimbursement system bases the capital payment to the owner upon the fair market rental value of the property. Each state that utilizes a fair rental value for facility capital reimbursement has introduced "twists" pertinent to their special situation. Thus, there is not any particular methodology that can be found in multiple States—only variations of the fair rental value approach.

Overview of Proposal

Underlying the current proposal are the previously stated objectives: namely, an equitable system of capital reimbursement that is simple and economical to administer. The category that best meets this objective is the Fair Rental Value which more and more States are gravitating toward. While the broad recommendation is to utilize a Fair Rental Value, there is within this category a great deal of diversity. Of the five States utilizing a version of Fair Rental Value, the Texas model showed the most promise as meeting other objectives such as being economical and simple to administer.

Texas computes a flat rate rental value per bed based upon the most recent local county property tax assessment. This is much cheaper than other States (in fact, no costs) that require certified real estate

appraisals that are subject to debate/appeal and other costly administrative issues. These outside independent appraisals often only serve to take money away from services and the facility owner. Texas applies a limitation of the 80th percentile or the prior years allowable fee adjusted for inflation. The rental factor utilized by Texas is a flat 14% and includes real estate taxes, insurance and moveable equipment along with other capital components.

North Carolina's Proposed Approach

A system similar to the approach taken by Texas is recommended for North Carolina.

- **Fair Rental Value.** The facility owner's capital costs would be paid based upon a "fair investment return" on the property's "assessed value" as determined by an independent party, e.g. the county tax assessor. In North Carolina, real property values are generally assessed every eight years for county tax purposes. Since property values can change dramatically in an eight-year period, there is an inherent need to adjust county tax valuations during the intervening years. Fortunately, the North Carolina Department of Revenue reviews prior year real property sales data annually for each of the State's 100 counties and compares the sales data to county assessed values for the same properties. Thus, the State is able to estimate with a high degree of confidence the current fair market value of property in each county based upon the statistical analysis. Real property assessment adjustments can easily be made during the intervening years between official assessment years with the aid of the North Carolina Department of Revenue statistics. The County assessed property value and the Department of Revenue data are both free (economical) and simple to administer which meets our objectives. An example of the adjustments for a sample facility in our sample is shown below.

Example of Real Estate Assessment Adjustment

	2003	2002	2001
County Assessed Value	252,800	252,800	252,800
NCDOR Adjustment factor	0.8060	0.8319	0.8477
Adjusted Assessed Value	313,648	303,883	298,219

- **Facility Type**. The adult care home payment rate is a single state-wide rate, as required by Federal regulations. We would therefore propose that payment rates continue to be established based upon a specified percentile ranking for non-capital costs.

- **Fair Rate of Return** – Texas employs a 14% fixed rate of return. While we were initially pessimistic about using a flat rate, our review indicates that North Carolina's computed rate is in line with Texas' rate. North Carolina's computed rate (12.6%) for 2001 is actually lower than Texas; however, Texas' rate also includes property taxes, insurance and movable equipment which is not a part of our recommended proposal as noted below. Other states use various ways of computing "fair investment return value" using a published rate, such as government investment yields plus an adjustment factor.

- **Capital Items.** The proposal substitutes a fair rental value (FRV) for the following cost items: depreciation, mortgage interest, building repairs and maintenance, and rent.

- **Excluded Capital Related Costs**

  We excluded costs which have a greater degree of variability, e.g. mobile/movable equipment, property taxes, insurance, etc. which can be considered either as capital costs or with other administrative costs separate from the major capital component. We see little value to including taxes, insurance or movable equipment in the fair rental value since they are not included in the county assessed value of real property and do not impact an "equity position" of assessed real property value.

Sample Study and Results

Methodology

In order to determine the impact that a proposal like this would have, we statistically selected a random sample from those adult care home facilities who had submitted cost reports for each of the three calendar years 2001, 2002 and 2003. Capital costs were obtained from the DHHS Controller's Office database. The primary capital cost components (depreciation, mortgage interest, leasehold improvements, building repairs and maintenance, and rent) were extracted. Assessed property values were obtained from either the tax notices submitted by the facility property managers or the county tax assessor's office (or their web site).

Approach Taken

In order to determine a fair rental rate, we:

- Statistically selected facilities from all except the small size (1-30) categories. (Smaller facilities were excluded since accurate cost data was not available for some of them. Facilities that did not have cost data for all three years were also excluded.)

- Obtained assessed real property values for the years 2001, 2002, 2003.
- Established 2001 as a "hold harmless" base year. The fair rental factor was set to equal the amount of actual costs reported by the facilities for 2001.

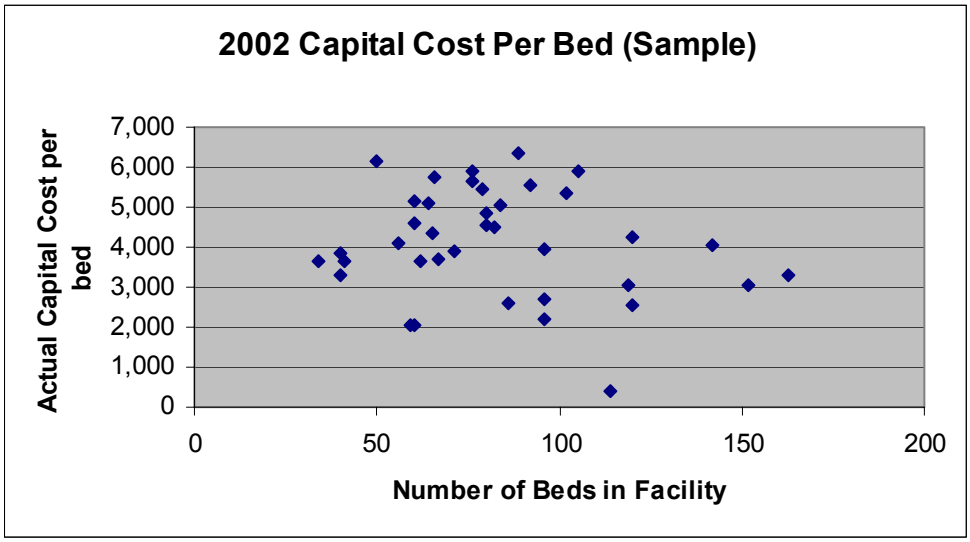
- Used the same rental rate developed in the base year 2001 to compute a fair rental value per bed for the next two years, 2002 and 2003.

- Totaled the actual capital costs reported to the Controller's Office on the Adult Care Home Cost Reports.

We then tabulated the total assessed tax values for 2001 and compared that value with the reported actual capital costs for 2001. From this number, we computed a fair value rental rate whereby, overall, the owners would have the same amount of capital costs from the fair rental value as from those costs reported to the Controller's Office.

We then compared the fair rental values per bed in 2002 and 2003 with the actual costs reported by the facilities to determine how much effect the proposed change in capital reimbursement methodology had on capital costs reimbursement.

The actual capital cost per bed varied significantly within the sample, from a low of $398 per bed in Oakhurst in Greensboro (114 licensed beds) to a high of $6,154 per bed for Autumn Winds of Bryson City (50 licensed beds).



Fair Rental Value Results

The year 2001 was established as a "hold harmless" base year in which the rental factor was set to equal the actual reported capital costs for the facilities in our sample.

Year	Adjusted Assessed Value	12.6% Fair Rental Rate	Actual Costs Reported	Difference	Rental Difference As a % of Actual
2001*	86,777,324	10,918,371	10,918,371	0	
2002	87,512,381	11,026,560	10,440,838	585,722	5.61%
2003	91,347,578	11,509,795	10,515,205	994,590	9.46%
* Base year of Study					

- As shown in the above table, application of the fair rental value for the 38 facilities in our sample resulted in an additional cost amount of $585,722 being included as equity cost in the year 2002 and an additional cost amount of $994,590 being reported in the year 2003 subject to inflation limitations more fully described below.

Fair Rental Value Limitations

In Texas, the current year fair rental value/fee is compared to the previous years allowable rental value/fee as adjusted for inflation based on the Implicit Price Deflator for Personal Consumption Expenditures. The lesser of the two is used as the basis for the allowable fair rental value increase. The Implicit Price Deflator is a better gauge for inflation since:

> *The IPD measures the prices of a much wider group of goods and services than the CPI. For example, the IPD includes all consumption of health care rather than just out of pocket expenses and consumer purchased insurance measured in the CPI. The IPD is based on current economic conditions and consumer expenditures, tastes and preferences. It is frequently used to adjust state economic and revenue data. The state expenditure limit is based on the IPD as well as inflation adjustments in the state's biennial budget*. [State of Washington Department of Finance]

> *Although it is up a bit recently,* ***the Fed's preferred measure of inflation -- the personal consumption expenditure price index****, excluding food and energy costs -- was a mere 1.4% higher in March than a year ago, well within the 1%-to-2% comfort range of many central bankers.* [BusinessWeek Online May 24, 2004]

Likewise in North Carolina, it would be prudent to place a cap on the amount of rental value increase in any given year. Application of the IPD would be as follows.

Computation of Additional Cost/Bed	2002		2003	
FRV limited to Implicit Price Deflator	FRV	Deflator	FRV	Deflator
Additional Capital -Fair Rental Value	5.61%	3.79%	9.47%	2.44%
Weighted Capital Costs in State Rate	0.3029	0.3029	0.3029	0.3029
Fair Rental Value Adjustment %	1.70%	1.15%	2.87%	0.74%
State Reimbursement Rate	$1,183.00	$1,183.00	$1,183.00	$1,183.00
FRV Effect on **Monthly** Reimburseme	$20.10	$13.58	$33.93	$8.74
FRV or Deflator Limit **Annualized per Bed**	N/A	$162.97	N/A	$104.92

Category	Cost Reports Weighted	Reimburse. pro-rated
Labor Related Costs	31.65%	$374.42
Other Costs	38.06%	$450.25
Capital Costs	30.29%	$358.33
Total	100.00%	$1,183.00

- **From a percentage view**, the limiting factor is the lower of the fair rental value increase (5.61%) or the Implicit Price Deflator (3.79%) for 2002. For 2003, the limiting factor is the lower of the fair rental value increase (9.47%) or the Implicit Price Deflator (2.44%).
- **From a fiscal impact standpoint**, the additional average cost increment/ reimbursement using the fair rental values (FRV) instead of actual capital costs reported would result in an additional $162.97 annually per bed for 2002 and $104.92 per bed for 2003.
- **On a monthly basis**, application of the proposed methodology would have increased Special Assistance monthly cost/rates by $14 from $1,183 to $1,197 per bed in 2002. For 2003, the Special Assistance monthly cost/rates would have increased by $9 from $1,188 to $1,197 per bed. These resulting increases are currently small due to the low inflation rates which have been experienced over the last few years. As inflation increases, the limiting IPD factor would also increase, providing a greater increase in allowable cost.

Conclusion

This report achieves its objectives in regard to providing a more equitable calculation of capital facility reimbursement than the current system based on historical costs. The methodology suggested is also economical to calculate and easy to administer. It also removes conflict of interest situations where facilities are sold to related parties. Further, it makes the State indifferent to management decisions such as capitalization policies, repairs that are expensed versus capitalized, etc.

While refinements can be and should be made to the proposed model, this report provides insight (3 years of data) into the potential impact of implementing this type of model. Thus, the proposed model appears to be a viable candidate for implementation.

Schedule 1

Implicit Price Deflator
Personal Consumption Expenditures

Background

The Bureau of Economic Analysis, U.S. Department of Commerce, publishes numerous statistics, one of which is the Price Index for Personal Consumption Expenditures. From the price index published, an implicit price deflator (IPD) may be derived for any time period. The price deflator is the measure of inflation between two points in time for the index being measured, in this case the personal consumption expenditure.

Obtaining the information

Step 1 – go to the Bureau of Economic Analysis web page main statistics page at http://www.fedstats.gov/key_stats/BEAkey.html.

On this page, select the Nation Income and Product Accounts (NIPA) which is located at http://www.bea.gov/bea/dn1.htm

Select the interactive NIPA tables.

Go to "List of all NIPA Tables"

Select Table 2.3.4 Table 2.3.4. Price Indexes for Personal Consumption Expenditures by Major Type of Product (A) (Q)

Select the date range and whether the information should be displayed annually or quarterly. For example, selecting annual for the last three years yields the following table of information:

Table 2.3.4. Price Indexes for Personal Consumption
Expenditures by Major Type of Product
[Index numbers, 2000=100]
Bureau of Economic Analysis
Downloaded on 5/18/04 At 11:23:26 AM Published date
is 4/30/04

Line		2000	2001	2002	2003
	Personal consumption				
1	expenditures	100	102.039	103.429	105.325
2	Durable goods	100	98.086	95.208	91.682
	Motor vehicles and				
3	parts	100	100.375	98.766	95.992
	Furniture and				
4	household equipment	100	94.139	88.778	83.538
5	Other	100	100.348	99.531	97.905
6	Nondurable goods	100	101.53	102.075	104.179
7	Food	100	102.944	104.942	106.966
8	Clothing and shoes	100	98.02	95.405	93.047
	Gasoline, fuel oil, and				
9	other energy goods	100	96.767	90.53	105.687
10	Gasoline and oil	100	96.337	90.415	105.259
11	Fuel oil and coal	100	101.695	91.778	110.164
12	Other	100	102.75	104.986	105.136
13	Services	100	103.168	105.946	109.007
14	**Housing**	**100**	**103.85**	**107.786**	**110.411**
15	Household operation	100	104.405	103.49	107.497
16	Electricity and gas	100	110.652	104.857	113.155
	Other household				
17	operation	100	100.827	102.715	104.193
18	Transportation	100	101.543	102.826	105.558
19	Medical care	100	103.643	106.241	109.444
20	Recreation	100	103.422	106.476	109.658
21	Other	100	101.831	105.419	108.455
	Addenda:				
	Energy goods and				
22	services\1\	100	102.655	96.601	108.888
	Personal consumption expenditures excluding				
23	food and energy	100	101.85	103.581	104.84

The results of the data can be summarized as follows:

Year	Current Index	Prior Yr Index	Divide Indexes	Deflator
2003	110.411	107.786	1.024	2.44%
2002	107.786	103.850	1.038	3.79%
2001	103.850	100.000	1.039	3.85%
2000	100.000			

The MDS Assessment Study, which is quite lengthy, is available only in hard copy. Please call the Office of Policy and Planning, 919-733-4534, if you would like a copy.